

# PATIENT PERSONAL/CONFIDENTIAL DATA

No. \_\_\_\_\_ Date: \_\_\_\_\_  
Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ SS No.: \_\_\_\_\_ No. of Children: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
How did you learn of this clinic? \_\_\_\_\_  
Nearest relative not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_  
Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_

## PATIENT'S INSURANCE

Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
ID & Group No.: \_\_\_\_\_  
Phone No.: \_\_\_\_\_

## SPOUSE'S INSURANCE

Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
ID & Group No.: \_\_\_\_\_  
Phone No.: \_\_\_\_\_

Purpose of this appointment and list your complaints: \_\_\_\_\_  
\_\_\_\_\_

Date of illness: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_

How did accident occur?  Auto  On the job  Other: \_\_\_\_\_

Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Doctor seen for this condition: \_\_\_\_\_

Have you been treated by a Doctor for any health condition in the last year?  Yes  No

If Yes, please describe? \_\_\_\_\_

## INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature Physician: \_\_\_\_\_ Signature Patient: \_\_\_\_\_

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

*I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.*

Patient Signature: \_\_\_\_\_

Patient's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

**ARE YOU PREGNANT?**  
 YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse

**SYMPTOM LOCALIZATION**

P \_\_\_ Pain  
 N \_\_\_ Numb  
 S \_\_\_ Spasm  
 T \_\_\_ Tender  
 H \_\_\_ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted?  Yes  No      Doctor's Signature \_\_\_\_\_